FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

June 19, 2015
Bernadette Wilson
Acting Executive Officer
U.S. Equal Employment Opportunity Commission
131 M Street NW
Washington, DC 20507

Re: Amendments to Regulations under the Americans with Disabilities Act NPRM (RIN 3046-AB01)

Families USA appreciates the opportunity to comment on the Equal Employment Opportunity Commission's (EEOC) proposed rule concerning the Americans with Disabilities Act's (ADA) application to wellness programs. Families USA is a national, nonpartisan, nonprofit advocacy organization dedicated to promoting policies to secure access to affordable, high quality health coverage and care for all in this country.

Families USA strongly opposes the EEOC's proposed policy to allow employers to implement penalties of up to 30 percent of the total cost of employee-only coverage for nonparticipation in medical exams or disability-related inquiries under the ADA's allowances for voluntary employee health or wellness programs.

Penalties of such magnitude could make coverage unaffordable for many workers and could easily be used to coerce workers to share private information or as a tool to shift costs to employees with health conditions or disabilities.

We urge the EEOC to withdraw this proposal and continue to interpret the ADA's requirement that "voluntary" medical exams and inquiries under a wellness program must not include any penalties (or absence of incentives) for failure to participate. This requirement should be implemented in the same way as the parallel requirements under the Genetic Information Nondiscrimination Act (GINA).

We offer the following comments regarding this proposed rule, including our concerns with the above proposed policy and recommendations on alternative policies and protections to better limit coercive incentives, strengthen confidentiality and programmatic requirements for wellness programs, strengthen notice requirements outlined in this rule, and apply this rule to tobacco-related wellness programs.

If you have any questions regarding these comments, please contact Lydia Mitts, Senior Policy Analyst at lmitts@familiesusa.org or (202)628-3030.

1630.14 (d)(3) Incentives offered for employee wellness programs that are part of a group health plan

The ADA makes it unlawful for an employer to ask its employees medical questions or to require them to take medical exams unless they are necessary to perform the job. This is an important protection: once an employer has information about an employee's disability, there is a greater likelihood that the employer will discriminate based on that disability.

The ADA makes a narrow exception for inquiries and exams that are part of *voluntary* wellness programs. Workplace wellness programs often ask employees to answer health risk assessments

(HRAs) about their health and behaviors, or to undergo biometric screenings such as body mass index measurements and blood tests. The EEOC has long interpreted "voluntary" to mean employers cannot require employees to participate nor can they penalize employees for nonparticipation in medical exams or inquiries that are part of a wellness program.

The policy proposed in this rule to allow such programs to include incentives of up to 30 percent of the total cost of coverage for employee-only health coverage is a concerning divergence from the EEOC's originally interpretation of this requirement. It would greatly undermine this important protection under the ADA and open the door to employers using economically coercive incentives that could render provision of medical information involuntary and threaten employees' access to affordable health coverage.

Increasing an employee's premium contribution by 30 percent of the total cost of employee-only coverage can result in employees facing hundreds to thousands of dollars in additional costs. According to the Kaiser Family Foundation, in 2014, the average premium for employee-only employer-sponsored coverage was $502 per month. In this scenario, a 30 percent penalty would increase an employee's share of health care costs by a little more than $150 every month ($1,807 over a year). ***Such a penalty would result in workers having to pay more than double what workers, on average, currently contribute towards health coverage.***[1]

These penalties will be financially coercive for many workers, particularly lower and middle income workers who may simply be unable to afford this additional cost. ***For low wage workers making barely $15,000 a year, a penalty of $150 every month would eat up 12 percent of their income. This doesn't even take into account the amount they have to pay for health coverage prior to this penalty.***

Furthermore, this proposed policy runs counter to both the ADA and the wellness provisions of the Affordable Care Act (ACA). The 2006 regulations from the Departments of Treasury, Labor, and Health and Human Services implementing the Health Insurance Portability and Accountability Act (HIPAA) explicitly recognize that the ADA imposes separate, additional restrictions on wellness programs.[2] And the 2015 "Tri-Agency" ACA regulations reiterate this interpretation of the three statutes:

> "[T]hese final regulations are implementing *only* the provisions regarding wellness programs in the Affordable Care Act. Other State and Federal laws may apply with respect to the privacy, disclosure, and confidentiality of information provided to these programs. For example . . . employers subject to the Americans with Disabilities Act of 1990 (ADA) *must comply with any applicable ADA requirements for disclosure and confidentiality of medical information and non-discrimination on the basis of disability."*[3]

---

[1] Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits Survey 2014* (Menlo Park: Kaiser Family Foundation, 2014), available online at http://files.kff.org/attachment/2014-employer-health-benefits-survey-full-report

[2] *See* 71 Fed. Reg. 75014, 75015 (2006).

[3] 78 Fed. Reg. 33158, 33165 (emphasis added).

We strongly recommend that the EEOC withdraw its proposal allowing employers to increase health care costs for workers who refuse to turn over their medical information. The EEOC should continue to interpret the ADA's requirement that "voluntary" medical exams and inquiries within a wellness program cannot include penalties (or absence of incentives) for failure to participate. The final rule should specify that this requirement is to be implemented in the same way as the parallel requirement in GINA: if financial inducements are offered to employees for completing a health risk assessment, the inducements must be offered regardless of whether the employee chooses to answer questions about medical information.[4]

Affordability Protections

While we believe no level of incentive should be permitted under this rule, if incentives are permitted there must be stricter standards to better limit the potential for financial coercion and protect all workers access to affordable health coverage. The current permissible incentives could make health coverage simply unaffordable for many lower and middle income workers if they do not participate in medical inquiries. Workers should not be forced to choose between obtaining affordable health coverage and protecting their private information.

We appreciate the EEOC seeking input on alternatives to better protect lower income individuals. Regarding the preamble's consideration of a standard that would cap incentives such that an employee's total premium contribution could not exceed the percentage set at 26 U.S.C 36B(c)(2)(c): We believe even this standard could permit coercive incentives, particularly for lower wage workers who, in reality, cannot afford to contribute nearly 10 percent of their income towards health coverage. In addition, we do have some reservations about establishing means-tested standards for applying disability rights that should be equally secured for all workers.

An alternative standard that is not means-tested would be to cap the magnitude of incentive at 30 percent of the *employee's premium contribution* for employee-only coverage. While this would not remedy the problem completely, incentives based on 30 percent of the employee's premium contribution for coverage are much less financially burdensome than the current proposal of basing the incentive on 30 percent of the combined cost of the employer and employee premium contribution.

If the EEOC is considering income-based standards, we think a more appropriate income-based measure of affordability within the ACA is the percent of income set at 48. U.S.C. 5000A(e)(1)(A). This sets the maximum percent of income individuals are expected to pay for coverage, for the purpose of implementing affordability exemptions from the individual mandate. If a consumer would have to pay more than this percentage of income to purchase health coverage, he or she is not required under the ACA to maintain health coverage. In creating

[4] Just as this rule is feasible under GINA because not all health risk assessment questions seek genetic information, the same is true under the ADA, since not all health risk assessment questions seek disability-related information. For example, typical HRAs may ask questions about whether a person uses sunscreen, eats whole grain foods, wears a seatbelt, exercises, watches television, drives within the speed limit, takes precautions to avoid workplace accidents, wears hats, avoids tanning booths and sunlamps, attends plays and concerts, and many other questions that do not relate to whether the person has a disability.

this additional affordability standard that is lower than that used to assess affordability of employer-sponsored coverage, the ACA recognized that for some individuals even coverage that meets the affordability standard for employer-sponsored coverage, at 26. U.S.C 36B(c)(2)(c), may still be unaffordable. Even this affordability standard is likely not an accurate measure of what percent of income many low income families can actually contribute towards coverage. However, we believe it is a more appropriate measure of affordability than the standard set for employer-sponsored coverage.

Exemptions for Employees that Provide Doctor Certification

We strongly support the proposal in the preamble that would require that in order for medical questions tied to financial incentives to be "voluntary," an employee must be offered similar incentives if she chooses not to answer medical questions and instead provides certification from a medical professional stating that the employee is under the care of a physician and that any medical risks identified by that physician are under active treatment. **This is an important reasonable accommodation, and the EEOC should include this protection in the final rule.**

In order for this accommodation to provide true protection for employees with disabilities, it is critical that the final rule strengthen the standards for this accommodation in the following ways:

The rule should clarify that the certification need only be submitted by a single health professional who may be a treating specialist or a primary care physician (or other professional such as a nurse practitioner or social worker) who is familiar with the worker's health profile. It would be unwieldy and impose prohibitive burdens on employees if the form required confirmation from all of the doctors treating an individual for various conditions or symptoms inquired about by the assessment. Moreover, many treating professionals would charge a patient for an evaluation in order to submit a certification. Particularly when multiple treating professionals are involved, such charges may be prohibitively expensive for many employees. Employers should be prohibited from requiring employees to obtain this certification from a health care provider selected by the employer. Such a requirement could place financial burdens on employees if they were required to see an employer-chosen provider in addition to their primary source of care. It also would disrupt their relationship with their regular health care provider who is most knowledgeable of their health condition.

The rule should clarify that this health professional should not have to disclose any information regarding the specific health risks an employee is managing. In addition, they may submit the certification without letterhead if the letterhead would reveal information about the patient's medical issues (such as an oncology practice). We recommend that employers be required to develop a template certification form that employees can use in obtaining this certification, in order to avoid concerns of conditions being identified through the provision of information such as a provider's letterhead.

Finally, we recommend that the final rule amend the language to replace the phrase "under active treatment" with "being effectively managed or treated." For many people who face medical risks due to a health condition, the appropriate course of action is not to provide "active treatment" such as medication, therapies, or other interventions but simply to monitor the person's condition on a regular basis and to intervene only if there is a particular reason to do so.

1630.14(d)(1) Proposed Rule and Appendix: Employee Health Program

We have long been concerned that wellness incentives that vary employees' health care costs based on completion of certain requirements are not an evidence-based strategy to improve health and reduce overall health care costs. ***Given the lack of evidence that these programs reduce overall health care costs through improved health, they present a huge risk of being used by employers in a discriminatory manner to shed workers with health conditions or disabilities from an employer's health plan or to shift costs to these employees as a method to achieve savings for the employer.***

We point the EEOC to the findings of the RAND study sponsored by the Departments of Labor and Health and Human Services. This study found that well designed wellness programs succeed in promoting employee participation *without the use of incentives*. The study notes that comprehensive programs with genuine corporate and manager engagement in wellness and commitment to monitoring and evaluating programs tend to succeed, without incentives. By contrast, limited programs, such as health risk assessment-only programs, tend not to inspire participation without use of incentives and tend not to reduce costs or improve health.[5]

As such, we have concerns with the explanations in the preamble and interpretive guidance of this proposed rule regarding what constitutes a "reasonably designed" employee health program. These explanations suggest that the rule would permit wellness programs that only offer a health risk assessment and alert people of health risks, but do not provide any additional services or activities under its definition of "reasonably designed." We do not believe Congress intended the "employee health program" exception to the ADA's medical inquiries provision to encompass programs that do not actually provide health services and only suggest that employees follow up on any potential health risks. Such program offers employees no evidence-based interventions to help reduce health risks, and as noted above, has not been found to be effective at improving health in formal evaluations. We have additional concerns that many health risk assessment based wellness programs may be used primarily to collect and sell data to third parties (see comments on page 7).

We appreciate the EEOC requesting input on wellness program best practices and urge the EEOC to outline more stringent standards as to what constitutes a "reasonably designed" wellness program in regulatory language under section 1630.14(d)(1) of the final rule and in its interpretative guidance. This is critical to ensuring that these programs aren't used for discriminatory purposes. Employers opting to use incentives that vary health care costs based on completion of disability-related inquiries or medical exams should have to make meaningful investments in evidence-based activities, classes, or health interventions to help improve employees' health.

We strongly recommend that the final rule clarify that in order to be "reasonably designed," wellness programs must have strong evidence that the design of their program, including any incentives, results in significant improvement in employees' health and significant reductions in health care costs as a result of health improvements. In addition,

[5] Soeren Mattke et al., RAND Health, Workplace Wellness Programs Study: Final Report (2013), https://www.dol.gov/ebsa/pdf/workplacewellnessstudyfinal.pdf.

the final rule should specify that a wellness program which generates a significant portion of its revenue from selling data to third parties should be deemed as not being "reasonably designed" to promote health or prevent disease.

It is equally critical that the activities required to obtain an incentive, including health risk assessments, are equally accessible and feasible to all employees and that employers do not set burdensome requirements that may be more difficult for some employees to fulfill. For example, some lower wage employees may not have reliable access to a computer and internet at home, which could make completing an online health risk assessment particularly burdensome.

We strongly recommend that the final rule establish stronger standards regarding what is required of a program in order to not be considered "overly burdensome." These standards should stipulate that employees must be allowed to complete all required activities on paid time and within the workplace if they desire. In addition, all required activities must be available at no cost to employees.

Application of Section 1630.14(d)(3) to Smoking Cessation Programs

We agree with the proposed rule's interpretation that biometric screenings or other medical exams that test for the presence of nicotine or tobacco would be considered a medical examination under the ADA, and thus required to comply with the ADA's "voluntary" medical inquiries requirements. This interpretation should be maintained.

The preamble requests comments on how this rule will interact with smoking cessation wellness programs. As previously outlined in our comments, we oppose the proposed rule's allowance of any penalties under the ADA's definition of a voluntary medical exam or disability-related inquiry. Evidence-based wellness programs do not need coercive incentives in order to be effective.

However, if this rule's proposed policy is maintained, we strongly recommend that the maximum permissible incentive NOT be increased for medical exams or biometric screenings used to assess the use of nicotine or tobacco. As outlined in our comments, the currently proposed maximum allowable incentive of 30 percent is already large enough to be coercive. Allowing employers to increase an employees' health care costs by even more than 30 percent of the cost of coverage for not completing a medical exam, even for a limited purpose, would only increase the opportunity for financial coercion. Furthermore, permitting different magnitudes of incentives based on the purpose of a medical exam would create an unjustified double standard of what qualifies as a "voluntary" medical exam. Whether or not a level of financial incentive is coercive does not change depending on the nature of the medical exam that the incentive is tied to: How could a 50 percent incentive be considered large enough to be coercive for one type of medical exam, but not for other types of medical exams? Such a double standard would completely undermine the ADA's limitation on medical exams and its definition of what constitutes as a "voluntary" wellness program.

1630.14(d)(2)(iv) Notice Requirements

We support the proposed rule's requirement that a wellness program that is part of a group health plan and asks medical questions must provide written notice describing: the type of medical information that will be sought and the specific purposes for which it will be used; the

restrictions on disclosure of the medical information; the employer representatives or third parties with whom it will be shared; and the methods used to prevent improper disclosure.

While such notice does not eliminate the primary problem created by the proposed rule, it is an important protection that must be maintained in the final rule.

However, we have significant concerns with the proposal in the preamble that would require employees to provide written confirmation that their participation in a disability-related inquiry or medical exam, and related wellness program are voluntary. As discussed throughout our comments, we have significant concerns that the magnitude of allowable incentive being proposed in this rule is coercive and could, in effect, compel employees to participate in disability-related inquiries. In addition, we have concerns that employers may use other tactics to compel employees to complete these inquiries. Requiring employees to affirm that their participation is voluntary when, in reality, they face coercive pressure to participate does not provide any benefit to the employee. We are additionally concerned that such requirement could infringe on employees' ability to pursue recourse against coercive actions by employers after the fact. **We strongly recommend that the final rule adopt notice requirements that specify that employers are NOT allowed to require employees to provide written consent that they are voluntarily participating in a disability related inquiry or medical exam under a wellness program.**

1630.14(d)(4)-(6) Proposed Rule and Appendix: Confidentiality Requirements

If the EEOC adopts its proposal to allow penalties up to 30 percent of the total cost of employee-only coverage, at a minimum, it must strengthen confidentiality requirements of wellness programs to minimize the harm created by such penalties.

The proposed rule references already-existing HIPAA confidentiality obligations that apply to group health plans operating wellness programs. In addition, the proposed rule would bar the provision to an employer of individually identifiable information collected by wellness program medical exams and inquiries "except as necessary to administer the plan." While we appreciate the EEOC taking steps to address confidentiality, these proposed standards have many limitations and must be strengthened to protect against improper disclosure or use of protected information.

The Health Insurance Portability and Accountability Act (HIPAA) protections referenced in the rule do not apply to employers, but only to the health plans operating the wellness programs. If these plans violate HIPAA by disclosing information to employers, workers have no recourse against their employers. Moreover, HIPAA's privacy protections are not privately enforceable. Individuals whose health information is impermissibly disclosed can file an administrative complaint with the Office for Civil Rights (OCR) in the Department of Health and Human Services (HHS). But OCR/HHS enforces compliance in only a tiny number of complaints and often takes more than a year to resolve complaints. Among the more than 115,000 HIPAA complaints OCR had received as of two months ago, it had initiated only 1,214 compliance reviews.

Given these limitations, it is critical that stronger standards, separate from HIPAA, are established in this rule to ensure that employers have robust procedures to protect the confidentiality of employees' information.

We also have significant concerns that some health risk assessment web sites may be used primarily to collect and sell data to third parties, and include a provision, often only displayed through a difficult to find link, stating that simply using the wellness program web site constitutes a waiver of the person's privacy rights. Under the "privacy policies and terms" of at least one of the larger wellness program websites, an employee who clicks on the website has automatically given their electronic signature authorizing the website to keep and sell their data. Employees should not be forced to waive their privacy rights or authorize the sale of their data in order to qualify for an incentive under an employee health program. Wellness programs that collect and sell data appear to be primarily interested in commoditizing the data as opposed to improving employee health.

The final rule should prohibit wellness programs from seeking waivers of (or automatically waiving) privacy rights under HIPAA through the completion of any requirements to obtain incentives under a wellness program, such as a health risk assessment. In addition, we recommend, at 1630.14(d)(1), that the EEOC specify that a wellness program which generates a significant portion of its revenue from selling data to third parties should be deemed as not being "reasonably designed" to promote health or prevent disease.

As proposed, the requirements at §1630.14(d)(6) have significant gaps as well. This provision permits information collected as part of an employee's participation in a wellness program to be provided to an ADA covered entity only in aggregate terms *except as needed to administer the health plan*. While we appreciate this intent of this provision to expand confidentiality requirements we believe this provision should be improved in a number of ways.

As written, the regulatory provision only restricts the information *that may be provided* to an ADA covered entity. The provision seems to only address the entity furnishing the data. However, the related guidance within the appendix clearly indicates that the intent was to ensure that both the employer (recipient) and the employee health program (data provider) are responsible for complying with the provision. **We suggest that 1630.14(d)(4) be revised to more accurately reflect the language in the interpretive guidance and expressly state that the program may not provide and the covered entity may not receive the prohibited information.**

As written, this provision permits information collected as part of an employee's participation in a wellness program to be provided to an ADA covered entity only in aggregate terms *except as needed to administer the health plan*. This exception seems quite broad and may become a venue for sharing large amounts of employee data. **We believe this permitted disclosure should be further limited to the minimum amount of information necessary for a specific administrative purpose, and encourage the EEOC to include specific examples in guidance as to what would and would not be considered minimally necessary for plan administrative functions. For example, if a financial incentive is tied to the completion of a health risk assessment, the minimal amount of information necessary for plan administrative functions should be limited to whether the employee completed the assessment.**

Such a limitation has precedence in the HIPAA Privacy Rule. We note that the absence of detailed guidance under that regulation has resulted in what many believe is a routine determination that the entire medical record is necessary for many administrative purposes. We encourage the EEOC to take steps to avoid this potential loophole.

Furthermore, EEOC should *require* employers to comply with the steps described in its Interpretive Guidance, at Appendix to Part 1630 regarding Section 1630.14(d)(4)-(6), rather than outline these as best practices. These steps are critical to ensuring that employers have adequate safeguards to protect the confidentiality of employees' information. This includes requiring that employers: adopt clear privacy policies (including prohibiting wellness programs from seeking waivers of privacy rights with respect to medical information furnished by employees where employees are penalized for not providing this information); train employees to protect private information; not allow employees who have access to coworkers' medical information to make employment decisions impacting those coworkers; and encrypt electronically-stored medical information.

Application of Rule to Wellness Programs Outside of Group Health Plans

According to the Kaiser Family Foundation, nearly half of large employer wellness programs and more than half of very large employer wellness programs (those with more than 5000 workers) say they are offered outside of the group health plan.[6] The EEOC's rationale for its proposed reading of the ADA's "voluntary" medical inquiries requirement in group health plan wellness programs is an asserted need to conform the ADA to the ACA/HIPAA provisions concerning wellness program penalties. For wellness programs outside of group health plans, there is no need to conform the ADA to the ACA and HIPAA, as the relevant provisions of those laws apply only to group health plans. **As such, for these wellness programs, we recommend that the EEOC retain its existing rule and disallow penalties (or absence of an incentive) for failure to answer medical inquiries or take medical exams.**

[6] Kaiser Family Foundation, 2014 Employer Health Benefits Survey, Section 12: Wellness Programs and Health Risk Assessments (Sept. 10 2014), http://kff.org/report-section/ehbs-2014-section-twelve-wellness-programs-and-health-risk-assessments/.